The College of Medicine is currently engaged in discussion and joint planning with the County of Orange to determine the scope and organization of the desired role of the University in the publicly organized health care system of this region. The College of Medicine earnestly seeks a role of leadership in such planning and is recruiting faculty with special interests in the planning of health care services. The curriculum of the medical student and the nature of post-graduate training will increasingly emphasize organized ambulatory care services to provide the educational experience necessary for practitioners in the 70's.

The Department of Community and Environmental Medicine set a tone for future development by incorporating into its area of teaching reponsibility the field of environmental toxicology. The Department's first appointee was Dr. Dwight Culver as Director of the Division of Occupational and Industrial Medicine. Dr. Harold Hodge was appointed, jointly with UC,SF, as Professor of Pharmacology and Toxicology with the cooperation of Drs. Elliott and Featherstone of UC,I and UC,SF, respectively.

Recently, the department was awarded a contract to manage and conduct research in the Toxic Hazards Research Unit of the Aerospace Medical Research Laboratory at Wright-Patterson Air Force Base. This contract carries with it a number of professional and technical personnel experienced in inhalation toxicology who have become part of the department and who will be engaged in collaborative work between that unit, the Department of Community and Environmental Medicine and investigators in several departments of UC,I, as well as at UC,SF, UC,D, and UC,LA. The capacity of the Department of Community and Environmental Medicine, of the Irvine campus and the University of California more generally, to develop basic and applied research and training programs in industrial and community problems of atmospheric pollution will be greatly enhanced by this affiliation. One aspect of Community Medicine, as served by the Department of Community and Environmental Medicine at UC,I, will become, therefore, a scientifically and technically oriented approach to physical, chemical and biologic health hazards in the environment. These should include within the Department of Community and Environmental Medicine and the College of Medicine, post-graduate training for physicians seeking board certification in Occupational Medicine, graduate and post-doctoral training in toxicology with emphasis on industrial and community exposure to toxic, carcinogenic and mutagenic hazards, and preparation of nurses, paramedical and technical personnel for this field.

The teaching activities of UC,I schools and programs outside the College of Medicine were recognized as important to the concept of community medicine. The department has participated by joint teaching and planning. The department has provided lecturers in health aspects of air pollution for the School of Engineering, has offered instruction in public health bacteriology for trainees under the Social Ecology Program, and seminars in medical care in community and industrial settings for students of the Graduate School of Administration. Coordination between the Department of Community and Environmental Medicine and other campus units will serve progressively to develop joint teaching activities at UC,I in several major areas of community medicine.

Refer to: Brayton D: California Regional Medical Programs—Area IV, *In* Community Medicine in California—A Symposium. Calif Med 118:75-77, Apr 1973

California Regional Medical Programs—Area IV

DONALD BRAYTON, MD

MANY PHYSICIANS who are privileged to interview applicants for medical schools have become aware during the past few years that an increasing number of these young people list "community medicine" as their ultimate goal. When asked to define this term, they describe one or another version of what most physicians would call family practice. I suspect few medical practitioners can define community medicine more accurately. Most, if they think of it at all, consider it a vague public health term associated somehow with barrios, ghettoes and out-of-the-way rural places. Despite

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its growing usage, a precise definition of the term *community medicine* is still a subject of disagreement even among public health planners, community health program administrators and other professionals close to the field.

Within the academic world the term is used broadly and has a variety of connotations. Many medical schools have established Departments of Community Medicine to give medical students field experience at a distance from the university medical center. Such experience may be obtained in neighborhood clinics or in other settings which may or may not be a part of a truly community-oriented medical project. Furthermore, the student may or may not be exposed to community medical organizational problems; usually he simply practices clinical medicine in the community setting to which he has been assigned.

Courses in community medicine in schools of public health constitute a vehicle for the student to reconcile and coordinate community health care needs with the available resources. Under this rubric the student also studies the regionalization of health services. This implies consideration of ways to equalize the quality and quantity of medical services among the various communities by (1) increasing the manpower and service capabilities of the communities themselves and (2) facilitating the two-way flow of medical expertise from centers of excellence to the communities and of patient referrals in the reverse direction.

If *community medicine* were used generally in the limited sense now to be described and illustrated, there predictably would be less confusion than now exists concerning the term. Assuming the word *community* is used either in its geographical sense or to denote a group of people having common social, ethnic or economic ties, *community medicine* then can be defined in either of two ways*:

1. The planning, provision and evaluation of medical care services to a community, or,
2. The delivery of health services in a community with concern about the population at risk.

In either case, the physician concerned with community medicine should be able to describe the population for which he is responsible, precisely, in the demographic sense. He should also have accurate knowledge concerning the nature and extent of the medical services the population is receiving and the nature and extent to which its health care needs are not being fulfilled. Although not all "health care needs" can be met by "medical services," it is important that the extent of both be consistently kept in view.

The physician who would undertake the discipline of community medicine must possess organizational capability and also must have (or have ready access to) demographic, epidemiological and evaluation skills. Obviously he also must have a source of funds. At present this source usually consists of reimbursement for medical services, or a government grant or a combination of the two.

If what is commonly practiced today is termed "individual medicine," it is apparent that the services delivered through community medical arrangements are individual medical services. Community medicine and individual medicine thus are interlocked and mutually supportive. The specialist in community medicine is essentially a medical organizer, administrator, manager or executive. However, by putting on another professional hat—if his time permits—he may also assume the more familiar clinical role of the physician by delivering personally some individual medical services within the community for which he is responsible.

The experience of Area IV of California Regional Medical Programs* has been interesting in relation to community medicine defined in this limited way. Most RMP operations have the potential for broad demographic impacts and are not targeted specifically toward the limited populations necessary to fulfill the above definition of "community." Consequently, all RMP health manpower programs, such as the training of pediatric nurse practitioners, and RMP projects calculated to improve generally the quality of health care, such as efforts targeted toward improving emergency medical services, must be considered too broadly directed to meet this definition of community medicine. Furthermore, even though each RMP program directed toward the improvement of the care of patients with categorical diseases has a definite target population (that is, all individuals having the disease) it does not seem reasonable to define this group of patients as a "community."

*Lewis, Charles E., MD, Professor of Medicine and Public Health, School of Medicine, University of California, Los Angeles; Director of Ambulatory Services, University of California, Los Angeles, Hospital. *Personal Communication.*

*Includes the counties of Madera, Fresno, Kings, Tulare, Kern, San Luis Obispo, Santa Barbara, Ventura and the southwest portion of Los Angeles County. Administered by UC,LA School of Medicine.

Dialysis, renal transplantation, stroke rehabilitation, mobile coronary care units and various screening activities are examples of this group of RMP projects. If these broad classes of programs, comprising a major part of the total RMP effort, are considered not to fall under the rubric of community medicine, are there any RMP projects that can be so classified?

In California RMP Area IV there are at least three programs which I believe can be properly termed community medicine endeavors according to the relatively narrow definition previously outlined. They are the Northeast San Fernando Valley Project, the Firebaugh-Mendota Project and the Ventura County Health Services Delivery Network. A brief description of each follows.

The Northeast Valley Project paved the way for a community health network for 250,000 residents of Pacoima, Sunland, Tujunga, San Fernando, Sylmar, Sun Valley and Lake View Terrace in the San Ferando Valley. This area is often referred to as a "health ghetto." Precise demographic measurements were made, data on the area's health needs were obtained and local services and facilities assessed. Priorities were established for development of the network, and community support by health professionals and consumers was generated. Following RMP development, this community health network has been placed in operation by the federal Office of Economic Opportunity.

The Firebaugh-Mendota Planning and Service Development Project is developing health care planning and delivery capabilities for the 15,000 residents of two adjacent farming communities in the Central San Joaquin Valley plus the migrant farm labor population. The Fresno County Medical Society, which has already contributed $10,000 to the project, acts as fiscal agent and provides overall direction, in cooperation with a broadly based community committee. Primary services will be provided in a health center staffed by volunteer physicians from the medical society and by residents from the Fresno teaching hospitals.

The Ventura County Health Services Delivery Network will serve 46,500 economically deprived residents of the county for whom health care is relatively inaccessible in their own neighborhoods. At present many of them must travel long distances to the County Hospital in the city of Ventura. The goal of the project is to improve the accessibility to health care for this group. A community health service center is being established in Santa Paula which will include decentralized eligibility billing and reimbursement for Medi-Cal patients. Other project components, to be phased in during the next three years, include the training of community workers to be employed by county agencies; training and employing at least 15 health counselors; establishing information and referral services; and augmenting the medical manpower capability of local hospitals by establishing a rotation program for family practice residents.

There is a definite and growing need for a precise definition of "community medicine" broadly acceptable to the practitioners, educators and students of the medical and public health professions. Otherwise this term—like so many others—will become a meaningless catch-all, eluding the standard of excellence so essential to its practical, purposeful and successful application.

Refer to: Mazur H: Community medicine at University of Southern California, *In* Community Medicine in California—A Symposium. Calif Med 118:77-79, Apr 1973

University of Southern California

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A DEFINITION of community medicine will depend greatly upon the person or group asked to provide the definition. From the point of view of the general public community medicine may well be defined as the availability of health care and medical care with minimal social, cultural, economic, and environmental barriers. If one were to focus further upon that segment of the public considered to be economically and socially underprivileged, one would have to add an additional component to the above definition—that is, community involvement, participation (and, in the opinion of some) control of the implementation of such health and medical care.

At USC, the Department of Community Medicine and Public Health has the three traditional obligations shared by all other departments of

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